Exhibit 3(g): Dey Labs

- J7613
- J7644

Employee

59-3493196

70

)5/0<u>6/2005</u>

Date Issued

Amount Paid:

\$20.62

HOLBROOK, MA 02343

File Copy

This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449

Claim No. 2890236

Goodlettsville, TN 37070-1449 Phone (615) 859-0131 Toll-free (800) 831-4914

Check No. 1412543

Explanation of Benefits

SMW+ Program



Comments:

Provider:

LINCARE PHARMACY SERVICES

Participant SSN:

SMG Claim Number: 2890236

11

LINCARE PHARMACY SERVICES POB 9515 AMHERST, NY 14226



Southern Benefit Administrators, Inc.

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	PKA J9541379	HEALTH INS	FURANCE CLAIM FORM PICA TTT				
	1. MEDICARE MEDICAID CHAMPUS CHAMPV	HEALTH PLAN BLK LUNG	1a. INSURED'S LD. NUMBER (FOR PROGRAM IN ITEM 1)				
	(Medicare 8) (Medicald 8) (Sponsor's SSN) (VA File 2. PATIENT'S NAME (Last Name, First Name, Middlo Initial)	S #) X (SSN ar ID) (SSN) (ID)	·				
	Z FATICIALS NAME (CASI NAIDE, FUST NAIDE, MIGOR) LTIGAL)	I NIM I DD I YY SCA I	4. INSURED'S NAME (Last Name, First Name, Middle Initial)				
	5. PATIENT'S ADDRESS (No., Sireel)	6. PATIENT RELATIONSHIP TO INSURED	7. INSUREO'S ADDRÉSS (No., Sircet)				
		Self (Spouse Child Other	1-1-1001 ED O NODI ED O (NODI)				
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	02343 1831 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	Student Student 10. IS PATIENT'S CONDITION RELATED TO:	02343				
	SAME	10. IS PAVIENT S CONDITION HELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER 496 8. INSURED'S DATE OF BIRTH OB 124 1753 M F 5. EMPLOYER'S NAME OR SCHOOL NAME C. INSURANCE PLAN NAME OR PROGRAM NAME 4. IS THERE ANOTHER HEALTH BENEFIT PLANT				
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	6. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME				
	E. EMPLOYERS NAME OR SCHOOL NAME	YES □XNO □					
	C. EMPLOYERS NAME OR SCHOOL NAME	C OTHER ACCIDENT?	C. INSURANCE PLAN NAME OR PROGRAM NAME				
	d. INSURANCE PLAN NAME OR PROGRAM NAME	10d RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?				
			YES NO If yes, return to and complete term 9 a-d.				
	READ BACK OF FORM BEFORE COMPLETING. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the	NG & SIGNING THIS FORM.	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE Lauthorize				
	to process this claim. I also request payment of government benefits eith below.	ter to myself or to the party who accepts assignment	payment of modical benefits to the undersigned physician or supplier for services described below.				
•	SIGNATURE ON FILE	2.75	STALLATING ON THE				
		DATE DATE	SIGNED SIGNATURE ON FILE THE DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION				
	MM DD YY MINLURY (Accident) OR PREGNANCY(LMP)	GIVE FIRST DATE MM DD YY	FROM 1 D 1 YY MM 1 DD 1 YY				
	I	7a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES				
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	IS RESERVED FOR COCKE USE	•	20, DUTSIDE (AB? \$ CHARGES				
	21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS	S 1,2,3 OR 4 TO ITEM 24E BY LINE)	YES NO				
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	ļ "· 	3	23, PRIOR AUTHORIZATION NUMBER				
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		UNIT DOSE MEDE					
	25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S	S ACCOUNT NO. 27, ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE				
	593493196	(For govt. dalms, see back) Y YES NO	\$ 121260 \$ \$ \$0 6				
	31. SIGNATURE OF PHYSICIAN OR SUPPLIER 32, NAME AND	D ADDRESS OF FACILITY WHERE SERVICES WERE	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE				
	(I certify that the statements on the reverse 4825	ED (14 other than home or office) 140TH AVE NORTH	LINCARE PHARMACY 800 882 0001				
		RWATER	PO BOX 9515				
	04 14 65	3762	AMHERST NY 14226				
			PINE 572852900 GRPs				
E	(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE BIRB) 90013329 J9541379	22. 32 FRI P/R: IAOOO	APPROVED CMB-0338-0008 FORM CMS-1500 (12:20), FORM RRB-1500, APPROVED CMB-0338-0008 FORM CMS-1500 (12:20), FORM RRB-1500,				

Electronic Remittance Notice MEDICARE PART B HEALTHNOW NY, INC. P.O BOX 6800 WILKES BARRE PA 18773 6800 Co: 90 Rg: 01 Ds: 33 Dr: 29 HINGHAM

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Exhibit 3(h): Fujisawa

- J3303
- J3302
- J3370
- **J7507**
- **J**1100
- **J**9000
- J9190
- J1580

SamTroni Bards, Nasinafic Hashville, Terresposes 37720	#*************************************	AUTHORIZED SIGNATURE			
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FO THE ORDER OF	CHARLES A. BIR 26 GUEEN STREE		0439624 ——	AUTHORIZED SIGNATURE	
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P.O. Box 1449

Goodlettsville, Tennessee 37070-1449 Toll-Free 800-831-4914 Phone (615) 859-0131

EXPLANATION OF BENEFITS

FROM DATE	DT DATE	CHARGES SUBMITTED	NON COVERED	CHARGES ALLOWED	COVERED CHARGES	AMOUNT PAID
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COMMENTS:

CLACH HUNBER: 1950522

FATICANTI, JOHN 51 PINE HILL RD

WORCESTER

MA 01604

SOUTHERN BENEFIT

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OTHER INSURED'S DATE OF BIRTH	1 SE	ĸ	b. AUT	O ACCIDENT?	PLACE (State)	b. EMPLOYER'S N	j AME OR S	CHOOL		<u> </u>	
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	(First sympto	m) DR	" 15 IE DATE	DATE	OR-SIMILAR ILLNESS.	SIGNED					
WOY I DO I AA . 🖷 BAYAAA	(Accident) OR WCY(LMP)		GIVE FIF	RST DATE- MM	DD I YY	16. DATES PATIE	T UNABLE DD YY	TOWO		MM	L DD I AA L OCCRISATION
7. NAME OF REFERRING PHYSICIAN		SOURCE	17a. I.D. NU	M8ER OF HEFERRIF	NG PHYSICIAN	18. HOSPITALIZA	ATAG NOO	S RFI 47	OT CH		INT SERVICES
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25. FEDERAL TAX LD. NUMBER 9.4 2 4 8 9 1 4 6 10. SKINATURE OF PHYSICIAN OR SI INCLUDING DEGREES OR CREDE [I certify that the statements on the re apply to this bill and are made a part	SSN EIN SSN EIN X IPPLIER NTIALS NOTAGE thereof.)	26. PA	J3303 THENT'S ACCOUNT 17165 ME AND ADDRESS	(For	1,2	16 0 29 TOTAL CHARGE \$ 226 33 PHYSICIANS ENHANCE ECHARLE 26 QUE	0 4	SBULIN BII TRE	202 IGNAM RBAI	80 E, ADD	30. BAYANCE DUE \$ 23 20 RESS ZIP CODE
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	NATIONAL	HERITAGE	INSURANCE	COMPARY
•	PROVIDER	#: H11203	3 .	
	CHECK JEE	r #.196771	1830	

06/28/02

125778830 100000806 CHARLES A BIRBARA MD INC PAGE #: 5 OF 13 NEMITTANCE NOTICE

PERF PROV	SERV DATE	POS N	<u>08</u>	<u>Proc</u>	HODS	BILLED	ALLOWED	DEDUCT	CO1NS	GRP/RC-AMT	PROV PD
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PROVIDER TAX LD. 0424891		<u> </u>	PATIENT ACCOUN	T# .		No 043	
	P.O. Bo	METAL WORKERS OX 1449 • GOODL	ETTSVIDE, NO.	ผู้อักษ์กที่อี	to to the	07/19 DATE ISS	
PAY ************************************	CHARLES A	AND 11CENT	7	0438625			. 11**
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Sun'irozi Barik, kisabaika Kautu-Du, Terramuun 1720	#00438625	Sur #2064.00	3046% 70	213903020		orized signature	•
	SHE	Toll-Free 800	P.O. Box 144 Isville, Tennesse	9 e 37070-1449 ne (615) 859-013	SM	W+ PROGRAM	
FROM DATE	TO DATE	CHARGES SUBMITTED	NON COVERED	CHARGES ALLOWED	COVERED CHARGES	AMOUNT PAID	•
06/11/2002	06/11/2002	345, 90	. 00	ਬ. 11	. 8. 11	8.11	
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COMMENTS:

UNDER THIS PLAN. \$100.00 WAS.

CHARGES APPLIED TO YOUR MEDICARE PART B DEDUCTIBLE ARE NOT PAYABLE APPLIED.

HPB CLAIN NUMBER: 1850\$23

FATICANTI, JOHN 51 PIME HILL AD

WORCESTER

01504

Processed by SOUTHERN BENEFIT

PLEASE	SHEET MET	TAL WORKERS			
DO NOT	NATIONAL	HEALTH FUNDE TENTAL			
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AREA D	•	SVILLE TN 37070			
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PICA .	HEALTH IN	ISURANCE CLAIM FORM PICA TITY			
***************************************	GROUP FECA OTHE HEALTH PLAN BLK LUNG	ER -			
) (SSN or ID) (SSN) (Z) (ID)				
•	3. PATIENT'S BIRTH DATE SEX III	T ′			
1	Ø3 14 37 M				
	PATIENT RELATIONSHIP TO INSURED	·			
	Self X Spouse Child Criber	<u> </u>			
WORCESTER		CITY STATE 2			
ZIP CODE TEL	MA Single Monted Other	7/0 CODE			
01604	Employed Full-Time Part-Time	ZIP CODE TELEPHONE (INCLUDE AREA CODE)			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Imital)	Student Student Student 10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER			
SAME		Z MOST COLD T GROUP ON PER NOMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH			
020289697A	YES XINO	MM 1 DD 1 YY SEX			
b. OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT? PLACE (State	b. EMPLOYER'S NAME OR SCHOOL NAME			
M F	YES XNO	ZIP CODE TELEPHONE (INCLÜDE AREA CODE) () 11. INSURED'S POLICY GRÖUP OR FECA NUMBER a. INSURED'S DATE OF BIRTH MM DD YY			
C. EMPLOYER'S NAME OR SCHOOL NAME	c_OTHER ACCIDENT?	C INSURANCE PLAN NAME OR PROGRAM NAME			
P.O.BOX 111 HINGHAM MA 020	144 YES XNO	C INSURANCE PLAN NAME OR PROGRAM NAME SHEET METAL WORKERS d. IS THERE ANOTHER HEALTH BENEFIT PLAN?			
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d, RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT FLAN?			
MEDICARE	i i	YES NO If yes, return to and complete item 9 a-d.			
READ BACK OF FORM BEFORE COMPL 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Tauthor	20 the release of any marked or other blomotics	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for			
to process this claim. I also request payment of government benefits	either to myself or to the party who occepts assignment	services described below.			
SIGNATURE ON FILE	07/03/02	SIGNATURE ON FILE			
14. DATE OF CURRENT; # ILNESS (First symptom) OR	OATE	SIGNEDY			
MM DD YY RURY (Accided) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAVE OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY	MM DD YY MM DD YY			
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. LD. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES			
JOHN KELLY		FROM DD YY MM DD YY			
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES			
		TYES TXINO			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, (RELATE IT	EMS 1,2,3 OF 4 TO ITEM 24E BY LINE)	22_MEDICAID RESUBMISSION			
7265	· • • • • • • • • • • • • • • • • • • •	CODE ORIGINAL REF, NO.			
"	<u> </u>	23. PRIOR AUTHORIZATION NUMBER			
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	(Explain Unusual Circumstances). DIAGNOSIS HCPCS MODIFIER CODE				
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6 TENERAL TAMES INC.					
	VT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For gov). claims, see back	28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE			
	342 YES NO	345 00 5 236 89 \$ 108 11			
I INCADDING DEGREES OF CHEDENTIALS RENDE	AND ADDRESS OF FACILITY WHERE SERVICES WERE RED (If other than home or office)				
(I cortify that the statements on the reverse : ' apply to this bill and are made a part thereof.)		CHARLES A. BIRBARA, M.D., INC			
CHARLES A. BIRBARA,		26 QUEEN STREET			
07/00/00	•	WORCESTER MA 01610			
SIGNED 0//03/02 DATE		Innia I A67226 N			

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-0008 FORM HCFA-1500 (12-80), FORM RRB-1500, APPROVED OMB-0720-2301 (CHAMPILS)

70

11/02/2005 Date Issued

Amount Paid: \$531.6

MEDWAY, MA 02053



File Copy

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SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449

Claim No.3093339

Goodlettsville, TN 37070-1449 Phone (615) 859-0131 Toll-free (800) 831-4914

Check No. 1605648

Explanation of Benefits

SMW+ Program

09/19/2005 09/19/2005 \$531.64 \$531.64

Comments:

Provider:

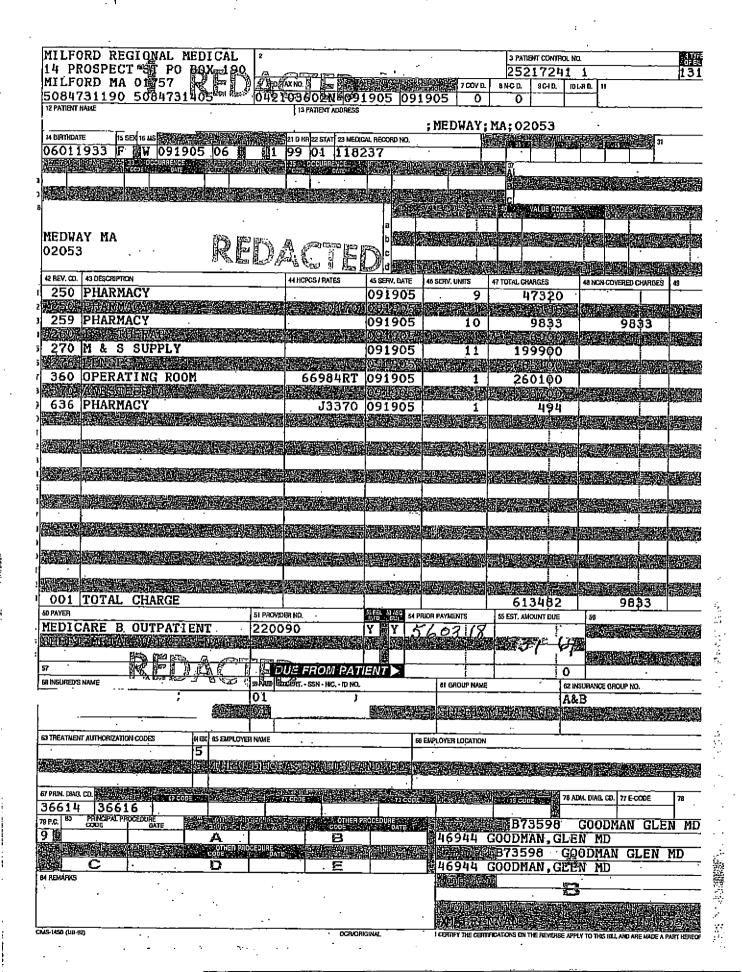
Participant SSN:

SMG Çlaim Number: 3093339

MILFORD REGIONAL MEDICAL CEN 14 PROSPECT ST MILFORD, MA 01757

Processed by





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	220090	109/30/20	05		·	1			2005	1010 PAGE 6
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Employee 05-0504251

> <u>07/12/2004</u> Date Issued

mount Paid:

WORCHESTER, MA 01606

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This is not a Check

SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449

Claim No. 2575096

Goodlettsville, TN 37070-1449 Phone (615) 859-0131 Toll-free (800) 831-4914

Check No. 1117117

Explanation of Benefits

SMW+ Program



Comments:

Provider:

PROCARE PHARMACY DIRECT INC

PROCARE PHARMACY DIRECT INC PO BOX 99794 CHICAGO, IL 60696

Participant SSN: DMA Claim Number: 2575096



PLEASE DO NOT LOCAL 52 HEALTH WELFARE IN THIS AREA GOODLETTSVILLE, TN 37070-	1449		
LOCAL 63	HEALTHIA	ICHDANCE OF ALL FORM	ا
1. MEDICARE MEDICAID CHAMPUS CHAM	PVA GROUP FECA OTHE	ISURANCE CLAIM FORM 18 1A INSURED'S LD, NUMBER (FOR PROGRA	PICA TT
(Medicare 3) (Medicald II) (Sponsor's SSN) (VA FI	CTHEALTH PLAN CTHER VIING	FOR PADER	MINITEM 1)
2. PATIENT'S NAME (Lest Name, First Name, Middle Initizi)	A PATIENT'S BIRTH DATE MM DD YY M SEX	4. INSURED'S NAME (Last-Name, First Name, Middle Initial)	
d Daysthan appears as	05 20 1956 MX	,	- 11
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
CITY STATI	Sell X Spouso Child Ciher	1	STATE SEA CODE) CHARACTER STATE
WORCESTER . MA	Single Married Other		STATE
ZIP CODE TELEPHONE (include Area Code)			MA D
01606	Full-time Statemen (1	S	REA COOLE)
9 OTHER INSURED'S NAME (Last Name, First Name, Middle mittar)	NO EXTENTS COMPTION DE LA FEUTE DE LA COMPTION DE L	101606 PA1. INSURED'S POLICY GROUP OR FECA NUMBER	
OTHER INCHAFTS PRIVATE AS ASSESSMENT OF THE PRIVATE ASSESSMENT OF THE		i	200
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX	
b. OTHER INSURED'S DATE OF BIFTH	1	05 20 1956 M D. EMPLOYER'S NAME OR SCHOOL NAME	[F] [4
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d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?	GARRIER PATIENT
MCR	<u>1 </u>	YES NO If yas, return to and complete ii	10-10-14 X
READ BACK OF FORM BEFORE COMPLETI. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authority the role CROSSS This claim. I also records resource to consequent benefit without the		13, INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I a payment of medical benefits to the undersigned physician of payment described believed.	
process this claim. I also request payment of government benefits either to r	nyself or to the party who accepts assignment below.	services described below.	r supplier for
SIGNED_SIGNATURE ON FILE			- 11
	DATE 06/26/04	SIGNED SIGNATURE ON PILE	<u></u>
MM DD YY (INJURY (Accident) OR PREGNANCY (LMP)	. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCU	PATION T
	a. I.D. NUMBER OF REFERRING PHYSICIAN	FROM TO 18. HOSPITALIZATION DATES RELATED TO CURRENT SERV	VICEE
PANG YEN FAN	BF3192921	FROM TO TO	"YY"
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES	
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· ·	. 1	22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
1.M42_0. KIDNEY TRANSPLANT STATUS	3	23. PRICH AUTHORIZATION NUMBER	
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			PHYSICIAN OR SUPPLIER INFOR
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Il and it is a second of the contract of the c		33, PHYSICIAMS, SUPPLIER'S BILLING NAME, ADDRESS, ZIP C	200E
opply to this bill and are made a part thereof.)	RE PHARMACY DIRECT, INC	PROCARE PHARMACY, INC.	
THE COURT WOLL IN I		PO BOX 99794,	
CCDCD V0/Z0/ZVV41	004 040=	CHICAGO, IL 60696 (412)824-24	87
1 (412)	APPRO	PIN F3 958898 GRP # OVED OWB-0520-0006 FORM CMS-1500 (12-90), FORM RRB-15	j\ <u>*</u>
(CPPTIONED BY AMA COUNTED, ON MEDICAL SERVERS 8:00) PATTACHMENTS: 11		THE CHE SEE FORM OWCE 1500. APPROVED OME-0720-W RCIAL - MAJOR MEDICAL/INDEMNI	

_2-005909-04174-G498704Z-00811-T-01-05239

ealthNow New York Inc. Provider #: 1272330002 Check/EFT #: 00000001741658 06/22	PROCARE PHARM DI /04 Page #: 004 of (RECT INC 005	MEDICARE REMITTANCE NOTICE	·
PERF PROV SERV DATE POS NOS PROC	MODS BILLED ALLO	WED DEDUCT COIKS GR	P/RC+AMT BROW BR	ı
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	(A 158.55 115. TALS 158.55 115. INTEREST 0.00 L	56 0.00 23.11 ATE FILING CHARGE 0	42.99 92.45 .00 NET 92.49	The state of the s
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Employee 04-3296910

> 12/01/2001 Date Issued

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Amount Paid:

HANOVER, MA 02339

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SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449

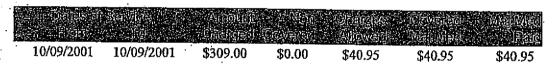
Claim No. 1618975

Goodlettsville, TN 37070-1449 Phone (615) 859-0131 Toll-free (800) 831-4914

Check No. 0142626

Explanation of Benefits

SMW+ Program



Comments:

Parking in the fire

COMMONWEALTH HEMATOLOGY O 10 WILLARD ST **QUINCY, MA 02169**

Provider:

COMMONWEALTH HEMATOLOGY ON

Participant SSN:

DMA Claim Number: 1618975





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(Medicare II) (Modicaid II) (Sponsor's SSN) (VA File	#) HEALTH PLAN (SSN or ID)	ECA OTHER BLKLUNG (SSN) XX(ID) 2	P	يخد بخا	.ees	·		1)
PATIENTS MANE Law News Form Many Services (NA File	3. PATIENT'S BIRTH DATE	SEX A		The second	5	ोटा सुरक्त क्यून हुन्छ	Mag	lnigat)
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STATE			GHY	-				STATE
HANOVER MA	Single Married	Other K						J.A.E
(02339	Employed - Full-Time		ZIP CODE			TELEPHO	NE (INC	LUDE AREA CODE)
04339	5judent 10, IS PATIENT'S CONDITIO	IIStuctÀntA'\A\	\mathcal{U}^{-}			_ (_)_	
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	→ WP (/	Μ Ω	a INSURED'S		YY A	ुष्यक्षि व्यक्त		
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EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?	<u>~</u> ~	- 410110 411					TEP.
•	YES	y.1v2	c. INSURANC SHEET					H FD
INSURANCE PLAN NAME OF PROGRAM NAME	10d, RESERVED FOR LOCA	(use 1)	d. IS THERE					
MEDICARE B		· · · · · · · · · · · · · · · · · · ·	Z Yes	□ N		yes, retum	to and c	omplete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING PATIENT'S OH AUTHORIZED PERSON'S SIGNATURE (surfnorize the to process this claim.) laiso request payment of government benefits either	PEDSON	e elema	TURE I authorize yalclan or supplier for					
below. SIGNATURE ON FILE	r to mysell or to the pouty who ac 11/	cepis assignment 09/01	services de	escribed be	bw.	ŔE O		
SIGNED	DATE	,	SIGNED	0201	uiio	100	LY I.	7.116
	IF PATIENT HAS HAD SAME O GIVE FIRST DATE MM : D	OR SIMILAR ILLNESS.	16. DATES PA	ATIENT UN	ABLE TO	WORK IN	CURRE	NT OCCUPATION
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SECOND INSURANCE

HIGHLY CONFIDENTIAL

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PLEASE	MAIL TO:	APPROVENCE
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IN THIS	P O BOX 1449	
AREA	GOODLETTSVII	LLE, TN 37070 00113
		SMWN 0001 LLE, TN 37070 00113 SECONDARY
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1. MEDIÇARE MEDIÇAID CHAMPUS CHAMP	VA GROUP FECA OTHE	SURANCE CLAIM FORM PICA [TT]
(Medicare #) (Medicard #) (Sponsor's SSN) (VA Fit	HEALTH PLAN BLK LUNG	R 1a. INSURED'S LD, NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Inklail)		<u> </u>
•	3. PATIENT'S BIRTH DATE MM , DO , YY SEX	4. INSURED'S NAME (Last Name, rhst Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Streat)	6. PATIENT RELATIONSHIP TO INSURED	
		7. INSURED'S ADDRESS (No., Street)
CRY		1
SPRINGFIELD MA		CITY STATE
ZIP CODE TELEPHONE (Include Area Code)	Single Married X Other	SPRINGFIELD MA ZIP CODE TELEPHONE (INCLUDE AREA CODE)
01118-0000	Employed Full-Time Part-Time	ZIP CODE TELEPHONE (INCLUDE AREA CODE)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle In(Kal)	10. IS PATIENT'S CONDITION RELATED TO:	1 ATTTR-0000
	THE PROPERTY OF THE PROPERTY O	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS)	a. INSURED'S DATE OF BIRTH MM DD YY SEX D3 O7 1937 M X F C
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C. EMPLOYER'S NAME OR SCHOOL NAME		THE STATE OF SLIPPOL NAME
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d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	SHEET METAL WORKERS NAT L
MEDICARE - MASS	- AND THE SERVED FOR COURT USE	
READ BACK DE CODIN DECORES COMON FORM	IG A SIGNING THIS ECON	X YES NO # yes, return to and complete item 9 a-d.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the process this claim. I also request payment of government benefits either below.		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of modical benefits to the undersigned physician or suppliar for sprives described below.
bolow,	a to mysen or to the barly who accepts assignment	services described below,
SIGNATURE ON FILE	DUTE 77 77 60	
	DATE11~17~03	SKINESIGNATURE ON FILE
14. DATE OF CURRENT: ILLNESS (First symptom) DR 15. MM : DD : YY INJURY (Accident) OR PREGNANCY(LMP)	IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DO YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
	1. I.D. NUMBER OF REFERRING PHYSICIAN	FROM TO MM DD YY
HETZEL, PAUL C.		18. HOSPITALIZATION DATES RELAYED TO CURRENT SERVICES MM DD YY MM DD YY
19. RESERVED FOR LOCAL USE	A68203	TO I
		20. OUTSIDE LAB? \$ CHARGES
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apply to this bill and are made a craft thereof t	IELD MEDICAL ASSOC	SPRINGFIELD MEDICAL AGOOD
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Date: 3/08/2004 Time: 4:25PM

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SPRINGFIELD MEDICAL ASSOC INC PO BOX 219 WINDSOR, CT 06095 Phone: (800) 883-5985

MEDICARE REMITTANCE NOTICE

Provider/Clinic#:

N51714

Check No/EFT Trace No: 127340082

Date Paid: 2/26/2004

NAME:

-500

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25. FEDERAL TAXLD, NUMBER 85. EN 21. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENTS For gov. claims, see heads, 38. ADA, IOI \$ 36. BALANCE DUE 39-1237-CHH-2 X YES NO. 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDINAL OF SHEED OR CREENING. 10. SHEWARD ADDRESS OF FACILITY WHERE SERVICES WERE INCLUDINAL OF SHEED	Б					<u> </u>					<u> </u>				
25. FEDERAL TAXLD, NUMBER 85. EN 21. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENTS For gov. claims, see heads, 38. ADA, IOI \$ 36. BALANCE DUE 39-1237-CHH-2 X YES NO. 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDINAL OF SHEED OR CREENING. 10. SHEWARD ADDRESS OF FACILITY WHERE SERVICES WERE INCLUDINAL OF SHEED	6	i i	!			1 !	. 10								
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DESPECTABLES (I) coulty that the determination the reverse apply to this billed are made a part thereof.) CAROLYN J. AHRENS 10/13/2000 SIGNED DATE 32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE PENDERED (I) other than home or office) CHARTWELL HOME THERAPIES DEPT. L-9657 COLUMBUS, OH 43260-9657 SIGNED PINA FORM HOPA-1500 GRAD FORM HOPA-1500 GRAD 10/13/2000 10/13/200	25. FEDERAL TAX I.D. NUM						(For go	vt. clourus, ean back)			. 1		_		
INTELLIBING DEGREES OR CEDENTIALS (I) could that the distance in the reverse apply to this bill end are made a part thereof.) CAROLYN J. AHRENS CORROLYN J. AHRENS 10/13/2000 SIGNED DATE RENDERED (I) other than home or office) CHARTWELL HOME THERAPIES DEPT. L-9657 COLUMBUS, OH 43260-9657 (800) 445-3496 PINS FORM HOPA-1500 (12-20)	31. SISNATURE OF PHYSII	CIÁN OR GUPPLIER							33. PHYSIC	AN'S, BUP	PLIER'S	BILLING	NAME.		S ZIP CODE
CAROLYN J. AHRENS COLUMBUS, OH 43260-9657 10/13/2000 SIGNED DATE DEF1. C-9657 COLUMBUS, OH 43260-9657 (800) 445-3496 PINI GRAPH FORM HOPA-1500 (1240)	- INCLUSING DEGREES	OR CREDENTIALS	, .	RENDER	RED (il olhe	r than home or offic	ze)		CHARY	fűell	HE	ME	THE	ERAF	IES
10/13/2000 (800) 445-3496 SIGNED DATE PINA (800) 445-3496		•	.					• •					. 3/3/	: G '	3 <i>6</i> 57
SIGNED DATE PINA GRPP FORM HORA-1500 (1240)	· .	10/13	3/2001	3					1	•		Ĺ	. (8		
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CASE #

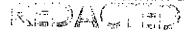
SHEET MENTAL WORKERS NATIONAL HEALTH FUND P.O. BOX# 1449 GOODLETTSVILLE, IN 37070-1449 PATIENT:
POLICY:
GROUP NUMBER:
POLICYHOLDER:
HOME CHEMOTHERAPY

DETAIL INVOICE

DATE OF SERVICE	DESCRIPTION	QTY		EXTENSION PRICE	
06/16/00 - 06/22/00	GLOVES CHENO LG EA	4.0	3.46	13.84	
06/16/00 - 06/22/00	EXT SET 12" LL (MINI)		4.40		
06/16/00 - 06/22/00	DISPENSING PIN, MINI	4.0.	5, 85	23.40	
06/16/00 - 06/22/00	. CLAVE NOLESS CHTOR C-1000	2.0	9.61	19.22	
06/16/00 - 06/22/00	BATTERY AA SIZE	B.0	9.73	77.84	
06/16/00 - 06/22/00	COVER, STER (LCAP)	4.0	0.68	2.72	
06/16/00 - 06/22/00	*** RX #: 292920	1.0	127.73.	127.73	
FLUOI	ROURACIL 2655MG/180ML				
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06/16/00 - 06/22/00	*** RX #: 292924	2.0	4.68	9.36	
•	0.9%-10ML SDV				:
06/16/00 - 06/22/00 HEPAN	*** RX #: 292925 RIN 100 U/NL-10HL	2.0	4.90	9.80	
00.410.00 00.00	*** *** ** pppp=1	· .			
06/16/00 - 06/22/00		2.0	0.55	1.10	
51K	IOCC LL .	•		•	
06/16/00 - 06/22/00 NDL,	*** RX #: 292927 #UBER W/TUB 22GX3/4"	2.0	12,09	24.18	
06/16/00 - 06/22/00	· ·	2.0	37.64	75 .28	
ACCES	SS KIT		·		
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-	. *** PLEASE PAY	THIS AMOU	NT	388.87	

PLEASE RENIT TO: CHARTHELL HOME THERAPIES
DEPT. L-9657
COLUMBUS, OH 43260-9657
042832765

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Date Issued

Amount Paid:

SO WEYMOUTH, MA 02190

File Copy

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SHEET METAL WORKERS' NATIONAL HEALTH FUND

P.O. Box 1449

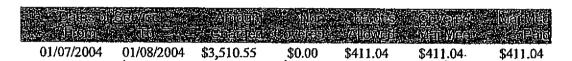
Claim No. 2554958

Goodlettsville, TN 37070-1449 Phone (615) 859-0131 Toll-free (800) 831-4914

Check No. 1098039

Explanation of Benefits

SMW+ Program



Comments:

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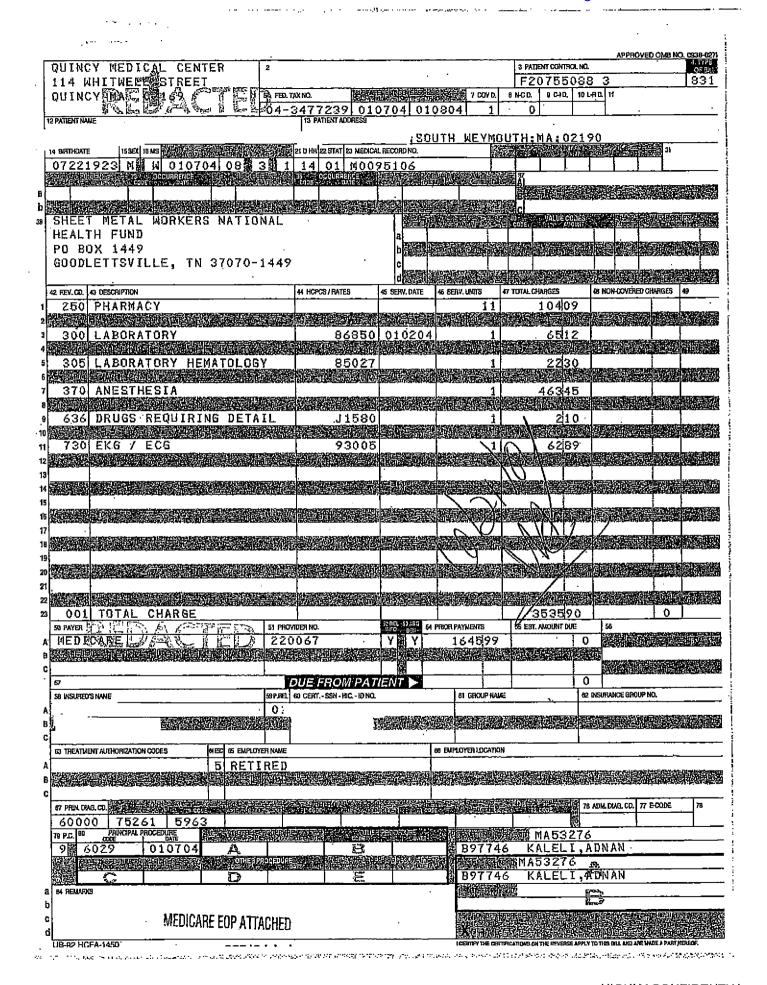
QUINCY MEDICAL CENTER 114 WHITWELL STREET QUINCY, MA 02169

Provider: Participant SSN: QUINCY MEDICAL CENTER

Dependent:

VLC Claim Number: 2554958

Southern Benefit Administrators, Inc. Processed by



220067	UINCY HEDICAL CENTER109/30/20041	0040518 PAGE 26
PATIENT NAME ICH NUMBER CLAIM BICLM ST NAME CHG-XX	PATIENT CNTRL NUMBER FEH DT COST REPTD CHGS DRG NBR	Interest Pat refund Perdiem amt Inet. Reinb
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